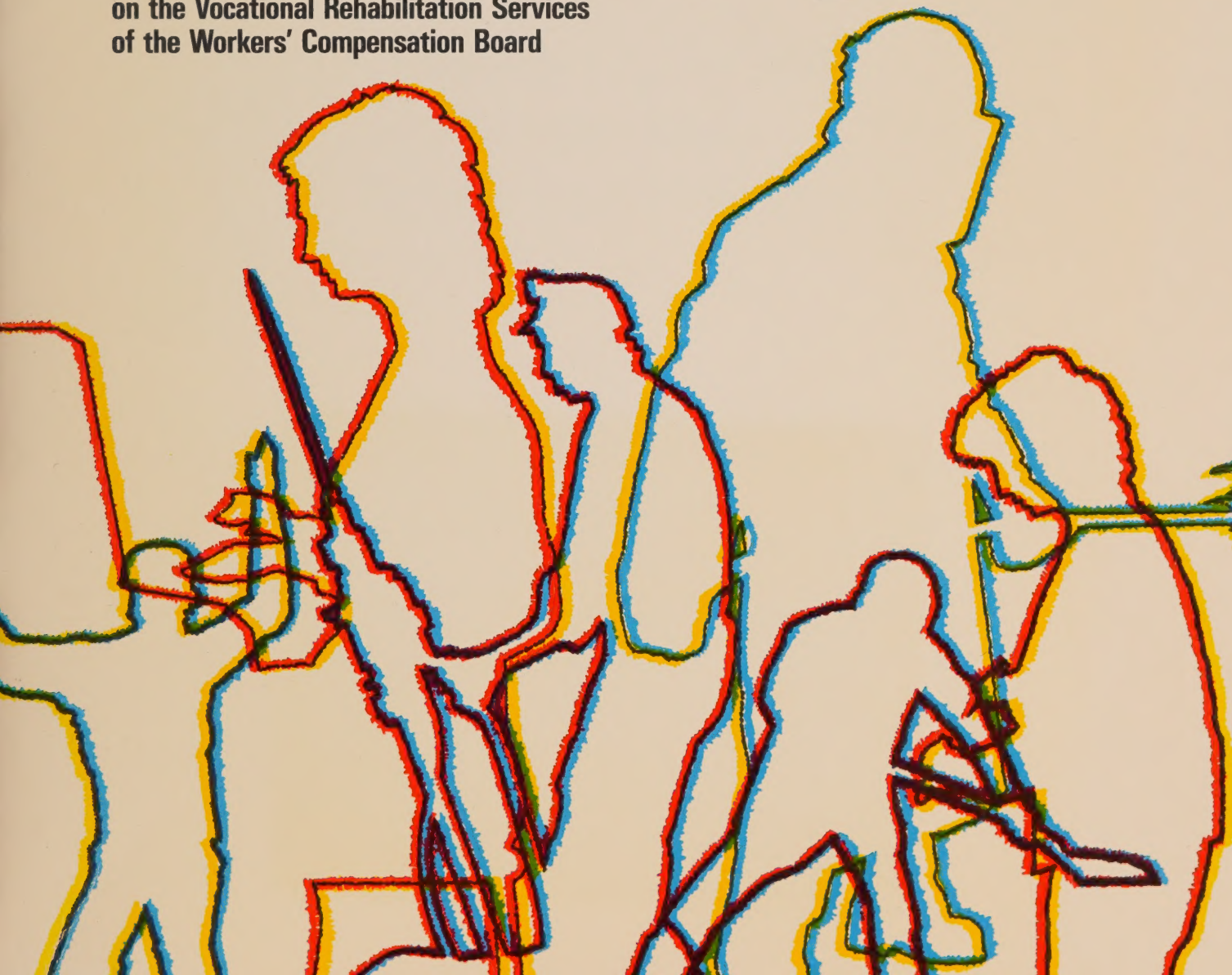
"an injury to one is an injury to all"

A Summary of the Report of the Ontario Task Force on the Vocational Rehabilitation Services of the Workers' Compensation Board



Erratum

A typographical error occurs on page 52, paragraph 5, line 1. The second word, "employees" should be "employers".

AN INJURY TO ONE IS AN INJURY TO ALL

Towards Dignity and Independence For the Injured Worker

A summary of a report submitted to the Minister of Labour on September 2, 1987

Ontario Task Force on Vocational Rehabilitation

Ontario

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The Injured Worker

According to the Ontario Federation of Labour, every six seconds of every working day a Canadian worker is injured. Every 12.7 seconds, a Canadian worker suffers a permanent disability. Every two hours one dies. Overall, Ontario statistics reflect a national trend of increases in numbers of disabling injuries which have far exceeded the growth of the work-force. According to a study of accident rates in the U.S. and Canada, these figures clearly demonstrate a rapidly deteriorating state of affairs in matters of work safety, despite the promises of the Occupational Health and Safety Act.

In 1985, 426,880 claims were reported across Ontario, an increase of 9.8% over 1984, with a corresponding 9.6% increase in serious injuries resulting in lost time. Most alarming perhaps is the marked increased in the proportion of high-percentage (50.1 - 99.9% disabled) permanent disability assessments to total awards over the past six years. (In 1985, awards in this category accounted for 34% of total awards granted, compared to 17% in 1981.) Preliminary figures for 1986 offer little hope for a reversal of this trend: total claims rose by 4% and lost-time injuries by 7.9% over the same time period in 1985.

The phenomenal rise in serious lost-time injuries and substantial number of pension awards point to a large pool of workers for whom a smooth reintegration into the workforce is impossible. Many of these workers could benefit greatly from timely access to vocational rehabilitation services. Unfortunately, the WCB assigns a very low priority to rehabilitation allocating a mere 3.3% or $24 million of its 1986 budget for vocational rehabilitation services.

Characteristics of VRD Clients

Many of the workers referred to the Vocational Rehabilitation Division (VRD) embody features most often associated with poor re-employment and rehabilitation outcomes. They are typically males in their mid-40s who have worked in labour-intensive blue-collar jobs. Low educational levels combined with lack of English fluency restrict the workers' ability to understand the intricacies of the WCB bureaucratic machine and result in few transferable job skills, thus limiting alternative employment options.

Many of these workers have back injuries which restrict their ability to bend, lift, walk, sit or perform prolonged or repetitive movements, effectively eliminating any hope of returning to manual labour. The disabilities are often severe, long-term and intractable.

Perhaps the most telling evidence for the severity of injuries sustained by this group is lost-time. Thirty-five percent of the sample were off work following injury for at least three years and the remaining 65% lost an average of 230 workdays. Seventy-four percent experienced a subsequent workplace injury, over half of which were reoccurrences or deteriorations of the original condition.

The employment picture painted by the workers is one in which attempts to return to work are interrupted by periods of relapse and recovery, necessitating reopening of cases with the WCB, further medical treatment, pension reassessments and appeals, seemingly futile attempts to find suitable lighter work and subsequent unemployment. Indeed, according to a Task Force survey, 73% of workers interviewed were not working and nearly 68% were receiving wage-loss benefits from WCB.

In comparison, statistics from the Vocational Rehabilitation Division (VRD) show that fully half of case closures result from the injured worker's re-employment. However the VRD does not keep records of how many injured workers remain employed after six months so unless the worker reapplies for VRD services, he is considered "rehabilitated" regardless of what his actual status is.

Those that do get jobs find their wages substantially reduced. Whereas only 22% of the 1986 closures were making less than $7.20 an hour before their accident, 41% were in this category after rehabilitation. The proportion of workers who had been earning more than $12.00 an hour before injury declined from 38% to 25.5% after rehabilitation. Recognizing the likelihood of a substantial drop in wages pre- to post-injury, WCB provides a wage-loss supplement to employed workers to help make up this difference. The supplement is in principle available for up to three years, during which time the worker is optimistically anticipated to have regained lost financial ground. In practice, however, actual duration of the supplement is discretionary and wage-loss benefits are usually terminated between six and 18 months.

For many workers, these facts spell poverty: 10% report having been on welfare, and a further 82% say their standard of living has decreased. Although many are homeowners, 13% state they have lost a home as a result of injury and subsequent financial problems, and a further 26% indicate continuing uncertainty about living arrangements. Many workers

are driven to take extreme measures to save family homes, and grown children, parents and other relatives may share living quarters and expenses to make ends meet.

Prolonged unemployment contributes to a profound sense of worthlessness and hopelessness. Workers describe a pattern of increasing loss of motivation and self-absorption in which they gradually focus on their disabilities rather than their abilities. Concentration on pain replaces constructive problem-solving. Financial and health concerns begin to dominate their outlook, and passivity, learned helplessness and depression become firmly entrenched as they wait for their doctors and counsellors to tell them what to do next. Seemingly endless confrontations with the WCB bureaucracy produce considerable anger and frustration.

Workers describe periods of alcohol and drug abuse, attempted suicide and family violence which they link to financial pressures, mental distress and pain. Most workers report serious deteriorations in their relationships with spouses and children and great disruptions in their social networks. Despite often serious personal problems, however, injured workers rarely request help from the VRD for such matters — and when they do the system does not seem to care.

Statistics from VRD sources and Task Force interviews indicate that typical VRD clients do not come into contact with VRD counsellors for some 18 months following injury. During this lengthy period the workers have been encouraged by medical personnel to think of themselves as "sick" and their only contact with the WCB has been a twice-monthly cheque in the mail. When they are finally deemed to be ready for vocational rehabilitation, they are contacted and interviewed by VRD counsellors who inform them they are now expected to actively conduct a job search or establish some plan of vocational rehabilitation.

This may very likely be the first time since their injury that each has been asked to adopt the role of a healthy person and they are understandably confused, apprehensive and skeptical about the prospect of finding a job. Their counsellors interpret their attitude as a lack of motivation or malingering, and threaten to cut off their benefits if they fail to co-operate in what appears to be a pointless exercise.

For the minority of VRD clients who are deemed "not job ready", the next step in the rehabilitation process is for the counsellor to establish a rehabilitation plan. A wide range of assessment and retraining options is available to the counsellor, but in practice access to these services is largely discretionary and their expense only justified as a last resort.

In particularly intractable cases, for example, workers may be ordered to go to the Downsview Rehabilitation Centre. Uprooted from their family and community, confused, anxious and in pain, they nevertheless co-operate because they hope the doctors there can help them. To their surprise, however, the doctors and therapists are not interested in their problems — they seem only to want to prove that, despite what their specialists say and what they feel, the injured workers are fit for "modified" work and do not deserve further benefits.

Injured workers described to the Task Force the inhumane treatment they received at Downsview. They are forced to stand for hours in lines, to carry their luggage and make their own beds although they can barely walk. Nothing is explained to them; examinations are cursory at best; and the treatments leave them feeling worse rather than better. If they complain or balk at treatment, they are accused of faking the extent of their disability. "It's all in your head," they are told. They know if they are labelled "unco-operative" they will lose their benefits. So they endure their humiliation and suffer in silence.

In a coordinated rehabilitation program, assessment would be the logical first step in determining the course of treatment or training. In reality, the purpose of assessments by Downsview and WCB personnel seems to be to limit entitlement to pensions and benefits and access to further services from the VRD. Often the determination of "fit for light work" is in complete contradiction to the reports of the workers' specialists who have examined them thoroughly and worked closely with them throughout their recovery. Nevertheless, the opinion of WCB medical personnel is invariably the one which decides the workers' fate and often, in the opinion of WCB doctors, the majority are fit for modified work.

Based on this assessment, workers looking for modified work are told to pound the pavement in search of elusive "light duty" jobs. The ideal work for them requires no lifting, bending or twisting, no repetitive movements and no prolonged sitting or standing. Where will 45-year-old disabled workers with less than a high school education find such work? Possibly their counsellor will find them one for minimum wage with a company with a high turnover rate. The workers discover that so-called "light" work is more taxing than their original jobs. In any event, when the "training period" is over and the subsidies to the companies expire, the workers could lose even these marginal jobs.

In desperation they look for jobs on the open market where they are forced to minimize or deny the extent of their disabilities in order to find

employment. They take jobs which are now far beyond their physical capabilities, re-injure themselves and once again begin the round of doctors, physiotherapy, pension reviews and VRD counselling.

At some point in this cycle, some workers may decide they have had enough. Although the compensation system was designed to eliminate the need for costly litigation, they discover they can cut through red tape much faster with legal representatives, MPPs or other advocates on their side. They may finally get a chance for some real rehabilitation, perhaps some training or upgrading which can make them more competitive in the employment market.

But the reality is that less than a quarter of clients who go through the VRD will get training and this figure has steadily declined over the past five years. Furthermore, a look at who is granted the rare privilege of training shows that those who need it the most are least likely to receive it. The older, less-educated workers with limited skills and English fluency are told there is no help for them. They must go and find jobs.

Even when injured workers are given the opportunity to participate in training, they lack any real input into decisions concerning their future. Workers who seriously desire retraining or education are denied the opportunity to pursue long-term goals to re-employment. Thrust into hastily considered training which do not suit them physically or temperamentally, workers experience considerable stress because they know failure will mean curtailment of benefits and another ride on the endless compensation merry-go-round.

VRD Closures

In 1986, 41% of VRD cases were closed for a variety of reasons and categorized under the heading "No Further Rehabilitation Action Indicated" (NFRAI). The title would suggest that for some reason, these workers no longer need help. However, excluding those individuals who have recovered or died, fully 33% of VRD closures result from the counsellor's perception that the worker has been unco-operative.

For example, workers may refuse to take jobs that their personal specialists have determined are beyond their physical capacities. They may suffer emotional disabilities which the Board refuses to regard as compensable, decline jobs they find demeaning, or refuse to relocate to take positions.

Workers pay a high price for their perceived non-compliance. First, they remain unemployed. Then they are terminated from the VRD and benefits are either reduced by 50% or totally suspended. Injured workers have the right to appeal this decision if they wish, but this usually means lengthy waits if they have to go before hearings officers and further delays if the claims go to the Workers' Compensation Appeals Tribunal (WCAT). During this period the workers must live on either their meager (10% - 20%) pensions and welfare.

Who are the workers most likely to fall into the NFRAI category? It is clear that they are the ones who are the least competitively employable and therefore most in need of rehabilitation. According to a Task Force study, they are the older, less-educated workers, employed in low-earning jobs prior to injury and now suffering from chronic or degenerative disabilities. They are the most likely individuals to return to the system again and again, who will cost the WCB and society more money in the long run because the system is designed to meet a bottom line, not to help those who need help most.

The Workers' Compensation Board: Its Philosophy

The *Workers' Compensation Act* was enacted in 1914 to provide a "no-fault" insurance scheme of financial compensation that would save injured workers and employers litigation costs offset by premiums paid by the employers. As long as the premiums were less than the feared legal costs, things ran smoothly.

But since 1914 premium costs have continued to rise rapidly and workers began to realize that, as an insurance scheme, the Act disallowed their suing for suffering and non-debilitating pain. It became apparent that the nature and extent of rehabilitation services were restricted to restoring employability and controlling the costs of running the WCB. Very little rehabilitation was offered that would reconstitute a life, damaged by an accident for which no fault was assessed — a life where functional, social and economic independence may have been lost.

Unfortunately the WCB is still driving the 1914 model of rehabilitation. Concepts of rehabilitation held before the First World War are still prevalent in Ontario despite society's conceptualization of, and attitude towards disabilities, shifting from the impact of the traumatic event towards a better understanding of its effects. There is no disciplinary body that certifies rehabilitation service delivery on the basis of quality and no school training rehabilitation counsellors at the graduate level in Ontario. There is no acceptance of the fact that the disabled are entitled to receive the best treatment the province can afford, whether they can be re-employed or not.

Close scrutiny of the messages unconsciously transmitted by words and deeds shows that the following four principles drive the model practiced today.

The First Principle

Rehabilitation services to workers, injured on the job in Ontario, are offered only as a last resort.

The *Workers' Compensation Act* of Ontario is clearly an insurance scheme whose primary focus is financial compensation. Rehabilitation is treated

merely as a supplementary service offered at the board's discretion and directed solely towards re-employment.

Of the 142 sections in the Act. Rehabilitation is relegated to a weak, nine lines of vague indecisiveness in Section 54 reflecting the disinterest of government and society of the early twentieth century. The Act stresses the economic commitment of that government to financial compensation and Acute Health Care and emphasizes that the WCB's purpose is to foster the worker's return to the job at minimal cost. In 1914 this may have been acceptable. However, today most of the western world is concerned with the injured worker, not simply as a cog in an industrial wheel, but as a human being.

At the WCB, rehabilitation is a last resort. As Section 54 states:

the board may take such measures and make such expenditures as it may deem necessary or expedient.

This attitude leads to inequality of treatment delivery and vulnerability of the staff to external pressure and internal prejudices. Rehabilitation is offered to injured workers by adjudicators who interpret a set of vague criteria based on grudging acceptance of the need to offer them rehabilitation services.

Even though the Act professes to be a "no-fault" insurance scheme, there is an underlying curr ent that pins guilt on the injured worker for having had the accident and this contributes to the determination of whether rehabilitation services will be offered. The no-fault basis of the workers' compensation system implies that workers are not to blame for their accidents, injuries or disabling conditions but, possibly because of the need to keep costs to a minimum, injured workers are often faulted and therefore seen as undeserving of rehabilitation.

The emphasis on saving money puts pressure on medical personnel and rehabilitation counsellors to severely limit rehabilitation services to the injured workers. It promotes an adversarial relationship between those injured workers who sense they must fight for what they should receive and the WCB staff who are afraid that the injured workers will exploit the system.

This adversarial process results in expensive court costs, repeated referrals to medical personnel for additional opinions, unnecessary vocational and work assessment and frustration and anger on the part of the injured workers. In the long term, the struggle to keep costs down may be far more expensive to the WCB, injured worker and society in general.

The Second Principle

The definition of rehabilitation is restricted to medical and vocational rehabilitation.

Section 54 of the Act states that part of the mission of rehabilitation is

to aid in getting injured workers back to work and to assist in lessening or removing any handicap resulting from their injuries.

Its interpretation is made as narrow as possible, and the service is restricted to a reduction or removal of any functional disablement that will help the injured worker return to work.

In the last decade, the emphasis in rehabilitation has shifted from physical and vocational rehabilitation to the reduction of disadvantages in all areas of life that result from an injury. Yet one of the underlying principles that drive rehabilitation is that it is restricted to medical and vocational areas and is directed solely to the reinstatement of a worker at the job. As long as this continues, the determination of employability will remain the responsibility of medical personnel, one that is not really in their field of expertise and one they are frequently reluctant to accept.

The Third Principle

Only job placement is acceptable as a successful outcome of rehabilitation.

In a society in which the work ethic is dominant, all adults ar expected to work or look actively for a job. Those who don't are considered by that society to be either sick or malingerers.

This tenet seems to be most apparent at the WCB in staff attitudes to workers with invisible injuries. These invisible injuries include physical disablements that are not readily identified by objective methods, such as migraine or lower back pain and psychological/sociological handicaps that result from the emotional trauma of injuries. They must be recognized and treated for their effect on injured workers which can be just as devastating as more visible injuries.

Invisible injuries are made worse by the length of time the condition drags on. Victims suffer from chronic emotional or physical problems that do not heal quickly. The WCB has no program for people suffering from invisible injuries. They are usually pensioned off according to a physical rating schedule sometimes referred to as a "meat chart", based on a fixed value for each part of the body and receive a fraction of their previous income. They are then thrust into the community to live on welfare, family allowance or income from other members of their family.

People who are not compliant and respectful of the system, people who may have psychogenic disabilities or are terrified of making a giant leap back into the work force are callously rejected by the board. It convinces society, including the injured workers themselves, that the responsibility for the accident and difficulties encountered in rehabilitation rest mainly on them.

Because job placement is the only acceptable outcome, rehabilitation counsellors are really vocational counsellors and receive little training in the evaluation of the mental and social impact of a traumatic event. When clients, who are reported by medical rehabilitation to be fit for light, modified work, balk at placement in meaningless jobs or inappropriate work that may lead to re-injury, some counsellors lack the insight to search for both the internal and external barriers that militate against re-employment.

Sometimes WCB staff get injured workers back to work by threatening to cut off their benefits. Time and again injured workers relate tragic stories of how they are cut off benefits because they can't find work on their own. These are workers who had spent years at blue-collar jobs, with families to support. The frustration and humiliation they endure is appalling.

The Fourth Principle

Paperwork is more important than people work.

Many organizations become preoccupied with administrative competence to the point where they lose sight of their mission. They become more concerned with reporting functions such as bookkeeping, statistics and annual reports than with the services they were meant to perform.

Human service organizations are especially vulnerable to the paperwork syndrome. The model of an industrial company that produces a large number of identical objects cannot be adapted easily into human services operations. Tracking the size of a caseload, the mileage travelled or the number of telephone calls made per day may make for interesting statistics and reports, but they contribute nothing to the quality of health service delivery.

The translation of this fourth principle into action has a number of results. Clients who are not compliant are rejected. Services that are difficult to organize and deliver are avoided. Clients may not be referred for rehabilitation services until pressure is brought to bear. Staff chafe

with a reported 40% of their time spent at paperwork. And follow-up services for clients whose files have been closed are not performed.

The Task Force has concluded that these four principles underlie much of the antagonism and confrontation among the various sectors of society and the Workers' Compensation Board.

Workers' Compensation and Rehabilitation Board: Its Philosophy

Clearly the principles underlying the present structure and process must be altered if any significant change is to be made. New principles must be established that reflect a more caring attitude towards and empathy for people who are injured on the job or contract an occupation-related disease. The value of human life must be respected and the preservation of an individual's dignity and quality of life must be at the core of our treatment of injured workers in Ontario.

Mission

The Task Force has therefore adopted a mission statement that will guide a model of rehabilitation to reflect these attitudes.

1. The Workers' Compensation and Rehabilitation Board is committed to the concept that workers, injured at the workplace, must have the opportunity to restore their competence to the maximum possible extent in all areas of disability — physical, mental, social, vocational and economic.

2. The Workers' Compensation and Rehabilitation Board recognizes that while re-employment is the primary goal of workers injured at the workplace, this cannot be the only goal, and that Workers' Compensation and Rehabilitation Board must be concerned with independence and stability of the injured worker in all areas of life.

3. The primary objective of the Workers' Compensation and Rehabilitation Board rehabilitation services is to help an injured worker identify specific employment barriers and to explore options to their removal, taking into account the realities of both the injured worker's areas of strength and limitation and the demands of the current, competitive employment market.

   To this end, counselling and assistance in personal adjustment, in appropriate and realistic settings, must be offered, as well as comprehensive vocational evaluation and assessment, training in competitive work habits, skill training, training in job seeking skills and assistance in appropriate job placement.

4. Workers' Compensation and Rehabilitation Board recognizes that the primary purpose of its rehabilitation division is to provide effective services by purchasing community and private services where

appropriate, to achieve the goal of maximum independence in all five areas of rehabilitation.

5. The Workers' Compensation and Rehabilitation Board, through its Rehabilitation Division, is committed to working actively with injured workers, employers in the private and public sectors, organized labour and the community towards the integration into the employment market of injured workers with physical, emotional or social barriers.

6. The Workers' Compensation and Rehabilitation Board, through its Rehabilitation Division, is committed to including the injured worker as an equal partner in formulating rehabilitation goals, identifying programs and developing services.

7. The Workers' Compensation and Rehabilitation Board is committed to assure that adequate rehabilitation facilities are available, run by the community for the injured workers in the province.

Structure

Claims, not rehabilitation, is the driving force behind the WCB today. The power to grant or stop benefits is invested in the same counsellor who offers rehabilitation. This double-edged sword is quite often used as a weapon against the injured worker as the counsellor threatens to cut off benefits if the worker is in any way unco-operative.

In order to provide effective rehabilitation, the functions of claims and rehabilitation must be separated and rehabilitation must be made a full partner in the entire process. The new importance of rehabilitation should be recognized in the title; injured workers and vocational rehabilitation practitioners must be represented on the corporate board; and the organizational structure must give the Vocational Rehabilitation Division the power to carry out its services.

The Right to Total Rehabilitation

The WCRB's goal of rehabilitation will be:

> *to assist workers who have suffered occupational injuries or debilitating diseases linked to the workplace in the process of restoration, to the fullest physical, mental, social, vocational and economic usefulness to the maximum possible extent.*

However, current rehabilitation services focus on medical and vocational services and are offered to injured workers only at the WCB's discretion. The decision is made by claims adjudicators and frequently under pressure from medical personnel, WCB administration, lawyers of the injured workers and others with political influence. The way service

delivery is determined is not only demoralizing to those who must make the decisions but destructive to those who receive them.

Rehabilitation is defined in its narrowest sense with the return of the injured worker to the workplace rather than with concern for the worker's dignity. Efficiency becomes more important, but at the same time the bureaucracy becomes top heavy and flow through the system is slow. Counsellors receive double messages. They are instructed to rehabilitate the injured workers but at the same time close cases rapidly and concentrate on paperwork. They are challenged to do their best but are not taught how to do it and more importantly, don't know what the board wants them to do.

Today the primary function of the Vocational Rehabilitation Division is to process injured workers through a system that receives them after they have received medical treatment and returns them to the same job or a similar one. There is little concern with their dignity, their quality of life or that they will continue to fall further behind their co-workers in income.

The Problems Faced

In examining the current rehabilitation process of the VRD, several problems are evident.

1. The system is slow. Things that could be handled at the same time are usually performed consecutively, frequently because no single person takes responsibility for a client.

2. Clients fall through the cracks and don't get the services they need in part because no particular counsellor is responsible for the client and counsellors must fill their quota of closures.

3. With duplication of files and different people located in several offices handling varied aspects of the case, communications becomes a contributing factor to cost and quality of service delivery.

4. Counsellors are hired who have never developed the skills of assessment and intervention and do not understand the demands and requirements of the workplace. Once on the job they do not keep current in their field or develop their counselling skills.

5. Counsellors are given double messages — "supply quality rehabilitation services but keep costs down". While statistics look good, clients are frequently dissatisfied.

6. Often services are unavailable in the local community. The WCB does not invest time, energy and money to help the community develop

them. When the board does offer these services itself, it often does it poorly, as the Review Team that investigated Downsview Rehabilitation Centre discovered.

7. The system favours injured workers with the greatest chance of becoming re-employed — the English-speaking young, well-educated and married clients.

8. The board has developed a number of ineligibility criteria which either limit or restrict access to vocational rehabilitation services.

9. The WCB may also be in conflict with the Human Rights Code so that the application of these ineligibility criteria could have legal consequences.

Dignity and Quality of Life Important

While re-employment is the ultimate goal of rehabilitation, vocational rehabilitation may not be appropriate for everyone. When desired, the injured worker must have the right to receive such services, but this should not be offered at the expense of other forms of rehabilitation. Nor should those, for whom re-employment is impossible, be relegated to the discard bin.

Rehabilitation should be offered in every area that affects an injured worker's life. The quality of life of an injured worker, his or her status within the family and within society, the individual's self-worth, dignity and independence must all be preserved.

While the work ethic is predominant in our society today, over 6% of able-bodied adults in Ontario cannot find meaningful work and there is a much larger group who have give up the struggle to find a job. These people must not be seen as pariahs. Rather they deserve the right to a decent quality of life. This is especially true of those who have incurred a disability at work. The right to rehabilitation must be inscribed in the Act and acknowledged with empathy and understanding in the service delivery system.

Hidden Caseload (Retroactivity)

There are a number of workers who were denied or never received rehabilitation services and have not recovered to the point of being able to return to work. There is no way to identify the extent of this hidden caseload, but it is estimated to be about 12,000 to 18,000 each year.

Many workers have also received inadequate services, especially in light of the extended, holistic definition of rehabilitation. Many are

under-employed and poor. The Task Force feels strongly that a case review should be carried out by the Worker's Compensation and Rehabilitation Board offering a full range of rehabilitation services to those who have been inadequately served the first time.

Regardless of the attempt by the Workers' Compensation and Rehabilitation Board to develop comprehensive and co-ordinated rehabilitation services for workers injured on the job and to involve the worker as an equal partner in the process, disputes will probably arise and an appeals procedure must be put into place.

Case Management

The Task Force recommends the adoption of a case management model of service delivery that assigns a case to a single individual, called a case manager, who bears responsibility for the outcome. The case manager ensures the injured worker receives the services needed to achieve maximum rehabilitation in a co-ordinated, effective and efficient manner.

Comprehensiveness and *continuity* of service provision are critical to the process. Working closely with the injured worker, the case manager must make certain that every appropriate rehabilitation service is offered and in a timely fashion. Continuity means that the client is not neglected, his or her file not lost in a maze of procedures or among other files, and that the services are delivered at the appropriate time. The client is seen as early as possible after the accident and the case manager has continuing responsibility for the client's rehabilitation.

Rehabilitation Services Providers

Essentially there are two bodies of knowledge and two sets of skills required to deliver comprehensive service in rehabilitation.

The first set of skills is embodied in the role of the rehabilitation counsellor trained academically to help people cope with personal problems. It centres on the identification and removal of internal barriers that restrict employability. These can be physical, emotional or social. A person who has the knowledge and skills to identify and remove internal barriers must be trained to appreciate the invisible components of physical injuries.

The second set of skills is required by the employment specialist who gains experience in the workplace. These skills focus on external barriers — those environmental constraints that make re-employment difficult. Among these are work conditions in the community, demands of the workplace and the factors that contribute to job satisfaction.

Employment specialists should have knowledge and experience of the work world. They should keep abreast of changes in employment opportunities in their communities, shifts in demand and requirements in various occupations and methods and style of work productivity. They should also maintain close contact with employers and organized labour and be aware of fluctuations and trends in availability of jobs and in the

requirements of the workplace. They should have backgrounds similar to those clients they are serving and wherever possible, have common ethnic, cultural and language ties.

Together the rehabilitation counsellor and the employment specialist help clients and communicate with the public on a daily basis to establish and maintain the reputation of an organization as well as save it unnecessary costs.

At the WCB today this central role is performed mainly by a claims adjudicator who determines the appropriate compensation and refers the client to the Vocational Rehabilitation Division. At the Workers' Compensation and Rehabilitation Board this function would be shared by the rehabilitation team members who would monitor the injury closely, intervene early and design and conduct a rehabilitation program specifically suited to the injured worker.

In the U.S. the determination of the client's vocational potential and strategies for re-employment is performed by "employment counsellors". These individuals have varied backgrounds, often trained to the bachelor's level, but with extensive experience in industry, business or the skilled trades.

Although their job descriptions list a broad range of functions, WCB counsellors state their jobs consist mainly of returning injured workers to employment and attempts to extend the sphere of service are frequently discouraged. At the WCRB, the actual responsibilities of rehabilitation counsellors will change to reflect the case management role and the need for effectiveness in supplying total rehabilitation services to the injured worker.

While most of the rehabilitation counsellors at the WCB are trained academically at least to a bachelor's level, the training rarely includes courses in understanding the behaviour of those who have suffered traumatic events, in counselling techniques, or in methods of serving people with physical disabilities.

They receive a nine-week training program when hired which focuses on an explanation of the administrative structure and service delivery model within which they will work as well as human behaviour in crises situations so they can intervene and help their clients. After this brief exposure to a body of knowledge that normally takes years to master, they are encouraged to learn more, but apparently little incentive is offered to do so.

The counsellors report that what little career advancement does occur is not based on knowledge or performance, but rather on personal relationships and "getting along" within the system. In the long run little advantage is taken of the opportunity to upgrade themselves, or even keep up to changes that are taking place, except by attending conferences as a passive audience.

The Task Force feels strongly that the role of rehabilitation counselling must be redefined and standards set for counsellors that would establish their importance and prestige as case managers. Defining rehabilitation counsellors as case managers implies they should be professionals who are knowledgeable and understand the community's needs. They should have the freedom to design and carry through individualized rehabilitation programs that will help return injured workers to employment whenever possible and to a life of dignity and independence.

To achieve this goal, the Workers' Compensation and Rehabilitation Board must employ counsellors who have training in counselling, empathy towards persons with disabilities and knowledge of the workplace. These employees must recognize that each person is important, possesses human dignity and has the right to equal opportunity.

At the same time, the Task Force recognizes that many rehabilitation counsellors presently working at the board do not have counselling training. While the Canadian Association of Rehabilitation Personnel (CARP) has accredited rehabilitation workers since 1971, it is on the basis of the length of time worked in the field, not on performance or training.

However, CARP is now proposing a new method of accreditation based on quality of experience, a set of skills and a philosophy of rehabilitation that is acceptable in our society. Those professing to become accredited would have to demonstrate their expertise through an examination. While this new proposal is only in the discussion stage at present, its acceptance would be a giant leap forward.

Another problem that emerges in discussions time and again not only with WCB counsellors, but suppliers of services, employers and injured workers is the heavy caseload borne by counsellors. In a Task Force questionnaire, counsellors reported they worked an average of 47.6 hours each week and had an average caseload size of 79.3 cases, indicating an optimum caseload would be about 53.

In a holistic program where purchase of service is emphasized and a case-management approach is introduced, the role of the rehabilitation counsellor will change greatly from what it is now. Caseload size will have to be monitored and expected to vary greatly with the nature of the work, type of client services and location in Ontario.

Early Intervention

Early intervention is an integral part of the case-management process. Based on a study commissioned by the Task Force, 10 reasons were cited for initiating rehabilitation services as soon as possible after the onset of a disability.

1. One can work with the disabled person and the family to prevent the development of psychosocial problems that could interfere with the outcome of the rehabilitation intervention.

2. There will be less confusion for the patient, who can go through the process of coping and adjustment with guidance when needed.

3. Early rehabilitation lets the individual make a personal commitment to re-establish a sense of order in his or her life.

4. The feeling of being alone and abandoned can be decreased or prevented.

5. The person's level of motivation to recover can be stimulated and/or kept high.

6. Family members can be immediately enlisted to provide positive reinforcement to the disabled person.

7. One avoids the waiting period during which patients often begin to build up resentment towards the family, the medical profession and the rehabilitation agency for delays in service.

8. The patient avoids the "runaround" or the feeling of being shuffled from one professional to another.

9. The secondary gains of being disabled can be kept in perspective.

10. Early intervention prevents the patient from settling into the sick role with the disability becoming a way of life.

However, despite its public espousal of early intervention, the WCB admits the average lag time between the date of an injured worker's accident and his or her referral for vocational rehabilitation services has been 17 months. In fact, reports from injured workers, employers and

professional organizations that supply rehabilitation services identify a much longer lag time then this.

Early intervention really means "early monitoring" of the injured worker. The case manager must become aware of and involved, in the entire recovery process, not only of the visible injury but invisible injuries as well. The injured worker should be visited in person as soon as possible after the traumatic event by someone trained and sensitive to the assessment of invisible injuries and able to intervene at the right moment.

Yet, because of difficulties in diagnosis or communications, delays can occur. If assessment takes longer than 30 days or the injured worker is not back to work within that period, the Task Force feels the injury should automatically be considered serious and the worker should immediately be referred to a case manager.

Assessment

There are basically three kinds of assessment used in the rehabilitation process: medical including functional, psychosocial, and vocational including work.

Medical and Functional Assessment

Medical assessment refers to an evaluation by a physician and/or a designate to assess the individual's degree of impairment. Functional assessment is an evaluation by a physician and/or a designate to ascertain the extent of a disability and degree of body function loss. The worker will be asked to perform certain actions which will reveal how much the disability will limit him or her. For example, a functional assessment may indicate that the grip strength of an individual's right hand won't allow him or her to hold a steering wheel. Another test might indicate that his or her eyesight is too poor to distinguish complex forms.

When the injury is serious, the first time the case manager will become involved is during Acute Health Care. At this point the client may have been assessed at a hospital and/or by the family physician. When the diagnosis is clear and uncontested, the case manager can assimilate the information and make the necessary plans for medical and functional rehabilitation.

However, this diagnosis and subsequent recommendations may be in conflict with that of another physician consulted by the board, the employer or the injured worker. At that point the case manager would request the Ontario College of Physicians and Surgeons to appoint a specialist to judge the dispute.

Psychosocial Assessment

Psychosocial assessment refers to an evaluation by a psychologist, social worker or psychiatrist, to determine how badly the worker has been affected or "handicapped" by his or her impairment or disability. Examinations may include psychological tests and interviews.

The assessment may identify areas in the individual's life which are creating barriers to rehabilitation. The impact of the injury may have had a traumatic effect on the worker's self-image, so that the worker believes he or she is incapable of performing similar work again. For example,

the head of the household has lost status within the family alienating them from his or her spouse and children. Such conditions are hidden injuries and may be as limiting to successful re-employment as are the physical, visible injuries.

At present, assessment by psychologists, psychiatrists and social workers is purchased on an ad hoc basis. Determination of purchase is made by the medical rehabilitation personnel or by the rehabilitation counsellor.

Little change is contemplated in this area except in regard to two points. First, the case manager rather than the medical practitioner should be the one who makes the referrals and receives the reports for psychosocial assessment. Second, with a holistic definition of rehabilitation, the need for assessment could be more frequent, reflecting a greater sensitivity to invisible injuries.

Vocational Assessment

Vocational assessment refers to an evaluation by a rehabilitation worker of the strengths and weaknesses in an individual's vocational plans. The assessor may be a psychologist, but just as frequently is someone trained in vocational counselling.

Vocational assessment is focused closely on the work to which the client will be referred and measures the strengths and weaknesses of the worker's physical and psychological readiness to choose an occupation, enter it and retain it.

Psychological tests directed towards vocational assessment will normally include personality inventories, intelligence tests, interest batteries and aptitude and achievement tests. Non-psychological tests may include aptitude tests and work samples such as VALPAR and TOWER.

The purchase of vocational assessment from psychologists and the private sector should continue in the future but with greater regard to input from the employment specialists.

Work Assessment

Work assessment is conducted with actual work and measures the degree to which an individual can be successful at a particular job. In practice, it is carried out in environments that most closely resemble the actual work to be performed. Assessment should therefore be made at the site under working conditions or if that is impractical, simulated work sites where the job is done under the direction and evaluation of a trained supervisor.

For instance, the ability to perform janitorial work is evaluated by contracting the worker with a company that provides these services. Another example might be one in which an assembly workshop is used to test the individual's ability to work successfully at an assembly job.

Work assessment should be a way of helping a client who has difficulties in formulating a work plan or one who is anxious about readopting a worker role after a long recovery period. today, unfortunately, it is a way out of a dilemma by desperate counsellors who cannot think of other solutions.

Frequently workshops are established which take contracts for such jobs as parts' assembly, packaging and labelling where individuals can demonstrate reliability, concentration, positive motivation, punctuality and quantity and quality of work output. Such work assessments are generally performed in shops run by non-profit agencies, such as Jewish Vocational Services, Goodwill and COSTI.

Work Assessment and Work Adjustment Training

While 1985 WCB figures show that 23% of all active cases in the Vocational Rehabilitation Division (VRD) began some form of assessment and 13% started training, the type or quality of programs, their direction and type of clients chosen for each are unknown.

The most likely candidates for work assessment programs seem to be older workers, usually in their 40's or 50's, with no job skills apart from those acquired during their working years. These workers might have been construction labourers, steelworkers, garment workers, miners or forestry workers, whose main assets were a strong back and an abundance of physical energy. Typically, these workers, especially in the urban centres of Southern Ontario, speak little English and have minimum education.

Under the current system, the outcome of an assessment will determine whether the injured worker will continue to be served by the VRD. A poor assessment usually leads the counsellor to conclude the injured worker is competitively unemployable.

No further rehabilitation services are offered and financial assistance in the form of pension supplements or vocational rehabilitation benefits are stopped. In some cases, a new assessment may be arranged but in many cases the worker simply accepts the assessment as it is and gives up.

Rehabilitation Workshops

Rehabilitation workshops generally combine assessment and retraining facilities in the same area. Many of them also include segregated employment services, that is, sheltered workshops. They offer services to people with severe physical or emotional disabilities who may never have experienced regular competitive employment.

Injured workers placed in a segregated workshop complain that the work is boring and tedious. They do not understand the reason they are there and when it is explained, balk at the need to be assessed on such basic factors as "ability to concentrate" and "reliability". So they lose interest, their productivity diminishes and they are frequently absent from

work. This leads to a negative report and the counsellor concludes that the injured worker is a malingerer.

In theory, on successful completion of a work adjustment program, the worker should be ready for some employment, likely at a lower entry level job. In reality, success rates, as measured by placement in competitive employment, are extremely low. The Ministry of Community and Social Services, the major funding source for workshops, has estimated that less than 6% of workshop participants are placed in competitive employment.

Serious concerns are raised about the adequacy of these programs and whether they do in fact prepare individuals for competitive employment.

The WCB must provide creative solutions for work assessment and work adjustment training. A large number of innovative programs exist in Canada and in the rest of the world from which the WCB could choose to sponsor or help to create. These would include such programs as competitive employment, supported work, enclaves, community-based workshops, sector-based centres and segregated employment.

Competitive Employment

Competitive employment for handicapped workers is greatly emphasized in the United States yet few national policies exist to promote disabled workers into the open labour market. Internationally one finds quota systems, government grants, wage subsidies and tax credits to employees as examples of government policies and initiatives that attempt to get disabled workers employed in open industry.

Supported Work Programs

It has been argued extensively that rehabilitation is based on the assumption that a disabled person must have certain pre-vocational skills before being considered for competitive placement. As a result, many severely disabled individuals who lack these skills have been denied access to mainstream industry. These people find their major vocational alternatives in rehabilitation facilities.

However, advocates for supported employment programs disagree with the need for these pre-vocational skills. Instead they offer a very labour intensive, step-by-step approach for achieving competitive placement. The supported work model places the disabled person in open industry, provides extensive job-site training and ongoing assessment, and, when necessary, receives job-retention assistance from a counsellor. This model emphasizes a "place-train" approach to competitive job placement as

opposed to the traditional "train–place" philosophy of vocational rehabilitation.

The labour–intensive aspect of supported work programs relates to the role of the rehabilitation counsellor. Project staff go directly to employers and identify potential jobs for their disabled clients before the employer meets the applicant in a well–rehearsed interview. The counsellor's role does not end with job placement, however. Staff remain involved with the employer and client on an as–needed basis to ensure successful work performance. Each job placement requires the counsellor to deliver on–the–job training to each disabled worker. Behavioural techniques are also used to teach clients to do their jobs more effectively.

Enclaves

This employment alternative is also referred to as work crews, job worksites, workshops–without–walls, work stations and satellites. Although each term may have a slightly different connotation, the basic concept of a small group of disabled workers in an industrial setting is evident from descriptions of these programs.

Generally, a section of the job site is set aside for workers with disabilities and they are paid either directly by the employer or through subcontracts with the rehabilitation facility.

Community–Based Centres

Although a number of innovative rehabilitation programs have been introduced, they have failed to make an impact on rehabilitation in general because the government has failed to assist in the innovative spirit to a sufficient degree. Community–based centres are normally established by the private, non–profit sector in the community. Unfortunately many of these centres are poorly equipped due to lack of funding to assess work readiness and perform the function of work adjustment training or work hardening.

Furthermore, although the Ontario Rehabilitation Work Council keeps a record of all existing workshops and has developed accreditation guidelines for performance, the actual services of the workshops are not monitored and they are not required to follow the guidelines.

Sector–Based Centres

Work assessment should first be found in the industry where the worker was previously employed. To this end, the larger industrial sectors of Ontario should be encouraged to provide worksite analysis to assess the extent to which a worker can return to a job within the industry.

The purpose of a sector-based centre is to perform work assessments and rehabilitate injured workers as much as possible within the industry itself. A number of large industry sectors such as mining, construction, automobile manufacturing and lumbering where a number of accidents occur could develop programs that will return injured workers to the workplace. This holds true for worksite modification and for the development of sector-based centres in communities where industries are located.

Where collective agreements exist within industry, both labour and management should be directed to protect the needs of injured workers and assist in developing and managing the sector-based centres. Where the work force is not organized, the community should participate in their development and management.

Segregated Employment

Few able-bodied workers are found in the traditional sheltered workshop segregated from mainstream competitive employment and subsidized by external funding to assure its existence. While there are many disadvantages to sheltered workshops, there are several examples of those that have met with success.

It seems that sheltered workshops in Europe do not function as social service agencies but instead take a very business-like approach to their operations. Compared to the U.S., the sheltered workshops in Europe tend to be larger, utilize more modern technology in their operations, pay workers competitive or near competitive wages, provide workers with typical fringe benefits found in industry, tend to be more integrated with disabled and able-bodied employees working together and emphasize long-term rather than transitional employment. While sheltered workshops in the United States are perceived as places for transitional employment until competitive placement can be obtained, European workshops are viewed as permanent, full-time employment for handicapped workers.

Guidelines to Re-Employment

The Task Force has developed six guidelines which serve as the basis for service delivery within the context of total rehabilitation as the right of all injured workers. They are based on the centrality of the client. People who work at jobs and are seriously injured must be cared for and restored to their previous, pre-injury level of quality of life as much as possible.

1. The preferred re-employment outcome is always the one that most closely approximates the pre-injury job.
2. Preference for re-employment options with competitive employment as the most desirable and no employment as least desirable.
3. The worker is an equal partner in the development of any program of work reinstatement.
4. The pre-injury employer should be consulted in formulating a vocational plan.
5. Rehabilitation services should be purchased in the community from non-profit and private service agencies.
6. Human costs and suffering, loss of income and quality of life, supersede administrative costs.

Mandatory Reinstatement

When the outcome is clear, the injury is visible and return to the worker's former job is straightforward and needs little energy or money, reinstatement tends to offer few problems. In 1985, 48.5% of the total claims made to the WCB were no-lost-time claims. The injured worker returned to his or her previous job without the need of rehabilitation services. However, in 1985 of the total number reported rehabilitated by the VRD, only 36% were returned to the accident employer either to the same job or a modified one with the same employer. In that same period of time, 46% were reported placed with a new company.

In interviews with a randomly selected sample of 120 injured workers who had received vocational rehabilitation services, few reported getting re-employment help from their pre-injury employer. Moreover only 34 of the 120 workers indicated that they were "very satisfied" or "somewhat satisfied" with the help they received from the previous company. Thirty-five percent of the interviewed workers stated their former

employers didn't help at all; 18% said they had been offered alternate jobs they couldn't do. Only one in four of the injured workers were offered their old position back, a different one or modified work.

The Task Force supports the worker's right to reinstatement and recommends that he or she have the statutory right to return to the pre-injury job or another job in the same company, respecting seniority rights.

Barriers to Re-Employment

In addition to their handicap, gender, language and cultural barriers also exist for many of the workers because of the difficulties in accepting people, who are different, as equal. They may be immigrants, or children of immigrants, Natives, agricultural workers or people who interact with society rarely because of location, religion or other cultural differences.

Rehabilitation services that approach rehabilitation holistically and focus on handicaps must also be aware of the external barriers to re-employment. Barriers may exist because the community doesn't have enough jobs to ensure the re-employment of the injured worker. The type of job to which the worker is accustomed may have disappeared, not only in the community but in society at large. Or employment conditions may make re-employment at the same or a similar job, in the same community impossible.

What are the figures on the re-employment rate? In the statistics gathered by the Task Force in its study of 120 injured workers, the re-employment rate with the pre-injury employer was 24%. The large majority of injured workers therefore have no alternative but to seek work elsewhere, often without the help of the board except for the threat of losing benefits within a fixed time limit if no job is found.

About 4,000 to 4,500 injured workers are relegated to informal and formal income support systems each year as a result of the VRD's inability to place them in jobs. The Vocational Rehabilitation Division conducts no follow-up of these cases to determine how these unplaced clients will support themselves though many will re-enter the WCB system through additional claims or appeals.

In an ideal system employers would be responsible for all workers injured at the workplace and return them to their pre-injury job, modified work or an alternate position. To this end, the Task Force has recommended that reinstatement be mandatory.

But in reality there are factors that make it difficult for reinstatement to occur: the company may no longer exist; the injured worker does not wish to return to the pre-injury employer; and antagonism and prejudice at the pre-injury job by management or fellow workers may make retention of the job impossible.

Under these conditions the WCB must be pro-active in reducing such barriers. The mission of the board must direct it to intervene in changing negative attitudes towards, and misperceptions of, injured workers.

Management Attitudes

There are a number of misconceptions about injured workers among employers. "Hiring an injured worker only means trouble for my company." "My insurance rates will skyrocket." "They need a lot of expensive worksite modifications." "Their safety records are poor." "Productivity will go downhill." "None of my other employees will accept them."

In fact, none of these statements is true. Earlier and more successful re-employment rates can actually decrease assessment rates. Worksite modifications are usually very inexpensive and if appropriate physical and social changes occur, safety records remain the same or actually improve. Several North American studies show that the productivity of injured employees is actually quite high and whether employees accept the disabled or not really depends on how management sees them.

So the reasons managers give for not hiring the disabled really have no basis in fact. Emotional objections are a little more difficult to address. For example, employers frequently feel that the "invisibly disabled" -- back-injured workers, in particular are malingerers. In fact, according to one study of 2,500 industrially injured workers, only seven were found to be fraudulent. Worse, there seems to be a common North American attitude, that people with disabilities somehow deserve them through their bad, inattentive or lazy behaviour. Moreover, some employers and co-workers simply don't know how to treat or react to an injured person.

Changing negative management attitudes requires communications, education and training to specific results-oriented, behavioral modifications. Positive management attitudes can lead to tolerant management practices toward people with limitations, significantly improving injured worker success and decreasing risk of further disablement.

Any special measures taken to socially integrate injured employees are more successful if dovetailed with general personnel policies and practices that ban discrimination and encourage equal treatment of all minority groups. For a group with physical limitations, the availability of sick time and health benefits, fair promotion practices and employment equity programs all encourage social acceptance of employees with disabilities.

Job Modification

According to the WCB's 1985 annual report, 103,130 workers received pensions for some degree of permanent disability in that year. In 1981, the WCB found that 40% of (non-active cases) injured workers were unemployed. Of this group, 70% had pensions assessed at less than 20%. These figures suggest that most of these people are employable. Their pensions certainly provide no financial incentives to remain unemployed. Evidently not enough is being done to maximize the potential contribution injured workers can make to our economy and their own lives.

Workplace modification expenditures should be viewed by both the WCB and the employer as investments that can save considerable financial resources in the long run and provide real help to injured workers as well as provide considerable prevention of future disabilities. However, job modification is one of the most underutilized programs at the WCB. Spending in this area in 1985 was only $56,013 and although it reached a peak of $101,938 in 1986 it is still a very small part of the $17 million Vocational Rehabilitation Division budget. Yet job modification has the potential of returning a large number of injured workers to the workforce where they can earn a living instead of just getting by on a small pension.

Job modification programs are designed to allow the injured worker to re-enter the workforce as quickly as possible. The reasons for this are apparent. The financial incentive of lower costs through lower lost-time accidents encourages such programs. Reduced costs can be achieved by cutting down on the number of accidents or bringing the injured worker back sooner.

If job modification were taken seriously, then the role of the ergonomist would be extremely important in the rehabilitation process of injured workers, both with accident and new employers. An ergonomically sound examination of the work process provides a dynamic link between health and safety and accessibility, addressing both the issues raised by the reintegration of an injured worker and prevention of similar

disabilities. To make this option more effective more employers should be made aware that Section 54 funds are available.

Training

Major changes in the structure of the economy, such as the shift from manufacturing to service jobs and the increased use of advanced technology in production, require a more educated work force. In this changing economy, unskilled, uneducated and older workers will have the most difficult time finding new jobs. Those that are disabled will find it harder still. The demand for an increasingly sophisticated work force means that any training provided should integrate basic skills upgrading with some form of vocational rehabilitation.

For many workers training-on-the job is the most appropriate form of rehabilitation and should be more effectively used, especially in conjunction with other forms of upgrading, and as an entry to a permanent job in the labour market. However, for those injured workers who have not been placed through the rehabilitation services and must anticipate a job search in today's labour market, formal training is likely to enhance their chances of finding meaningful work and should be offered to a greater extent.

The training programs which are used by the Vocational Rehabilitation Division range considerably in their target groups and goals. They include English as a Second Language, training-on-the-job, and formal training programs for technical upgrading, educational upgrading, business training and post-secondary education.

Despite a rapid and continuous rise in the number of workers referred to the VRD over the past five years, the proportion of individuals who began training programs in this period has failed to keep pace. In fact, there has been a steady decrease in the proportion of workers who have gained access to training, from 39.4% of referrals in 1980 to 23.2% in 1985. Thus, only about one-quarter of the injured workers who are deemed eligible for rehabilitation services will get an opportunity to prepare themselves in some way for a relatively hostile labour market.

Training expenditures have also decreased, both in terms of the percentage of Section 54 expenditures allocated to training and in actual dollars spent on training, from about $2.1 million in 1983 to $1.9 million in 1985. Furthermore, for every dollar the board spent directly on rehabilitated workers in 1985, it spent more than $3 on the administrative system to deliver this service. Clearly, spending priorities need to be realigned.

Vocational rehabilitation must not be tied to the degree of disability but to the level of skills required to get a new job. For example, by far the largest majority of claims involved back disabilities. While vocational rehabilitation service might be limited to counselling for job search, what is really needed is retraining or skill upgrading to get access to the type of work which will not make this condition worse.

ESL would be more effective if offered in conjunction with whatever form of training is being provided the injured worker. It should reinforce what is being taught in the program, covering such topics as job search in the related area, health and safety issues referring to the job, tools, techniques and terminology common to the occupational area. Verbal communication should be stressed over written work such as grammar and spelling. Formal training in university and community college programs must be viable options.

Any program which is offered injured workers, especially ESL and vocational training, should be based on their particular requirements. If a worker has gone through upgrading before the accident he/she should have the right to continue to do so after. If the injured worker is entitled to rehabilitation services and wishes to upgrade to a Grade 12 level of education along with vocational retraining, this should also be a right. Completion of upgrading programs such as ESL should not limit access to further training programs. All injured workers should have a right to formal academic or technical training if this is established as the best route to successful rehabilitation in their individual situation.

Communications

The lack of good, open communications has contributed to confusion and a lack of trust among the WCB, injured workers and employers. This failure to communicate may be caused by language barriers, lack of information to injured workers, the workers' fear of negative consequences if rehabilitation services are requested and failure to listen to the injured workers or admit they may have invisible injuries.

Reasons for the failure to communicate clearly lie in the WCB principles that rehabilitation services are a last resort and money and paperwork can be saved if the injured worker is denied services. But the Task Force feels strongly that goodwill of the injured workers will be obtained, complaints among the public will be reduced, satisfaction and morale among the staff will grow and, in the longer term, money will be saved, if the Workers' Compensation and Rehabilitation Board takes a pro-active role in ensuring that the injured workers are aware of, and participate actively in the development of all rehabilitation services programs.

Injured Workers

The major complaints came from injured workers, especially those who didn't speak English. They complained about the difficulty in understanding what was expected of them and the troubles they encountered trying to tell the WCB their problems. According to a Task Force study, 51.7% of injured workers do not speak English fluently and over 30% have less than a Grade 8 education.

Even when a worker's ability to speak English is fairly good, the next big hurdle is taking on the intricacies of the WCB bureaucratic machine. Correspondence from the board is confusing to even the best-educated reader and incomprehensible to the poorly schooled, older non-English speaker. The system seems arbitrary and unnecessarily bogged down in red tape. Workers who receive assessments at the instigation of the VRD don't understand why they've been given the tests and rarely see the results.

Clearly, counsellors must be able to transcend cultural and language barriers before they undertake case management. They must undergo intensive courses in counselling techniques of the disabled and culturally

diverse. Injured workers must be contacted as soon as possible after the accident and informed of their rights and obligations.

Employers

The employers also had problems with understanding or identifying the sources of the pronouncements that came from the WCB — whether general statements about procedures or decisions in specific cases. Employer concerns with communications centred on the lack of information they receive from the VRD regarding the roles they must play in case of an accident, and in their inability to identify responsible staff when needed.

In the WCRB, employers will be kept informed about rehabilitation services by the director of communications in the division and procedures will be organized so that continued communications with employers are maintained on a two-way basis. At the same time, the front line-staff of the division will keep the lines of communication open.

Staff

Finally, the counselling staff complained about the lack of communications within the organization and with agencies and employers. They felt that decisions were being made about their clients by personnel in the claims division without sharing information. They argued that agencies were not giving them feedback when it was needed and of the type that was required.

Many members of the VRD staff are on the road and come into the office once a week. There they pick up informal gossip and have no ways of separating rumours from directives. To help reduce tensions, regular meetings should be held to allow staff to share problems, information and advice that will help them do their jobs more effectively.

Research Needed

With close to half a million claims made each year the WCB could become an important source of knowledge about rehabilitation procedures and helping people who have accidents. Yet if any program evaluations have been conducted, needs assessments or outcome measures studies performed, the results have not been made public. There are no internal staff who are able to conduct such research independently and rarely has the WCB invited such studies externally. In fact, when outside researchers have requested permission to conduct studies of board clients, they have been refused permission.

Two kinds of research could and should be conducted applied research that will help to improve the effectiveness of service delivery of the WCB and basic research that will inform rehabilitation practitioners of the nature and consequences of work–related injuries and diseases. Such research would improve rehabilitation services both within the board and the field in general.

The Need for Regionalization

The present form of service delivery to injured workers in the North is wholly inadequate. Two predominant factors underlie the growing dissatisfaction with the high cost and time delays in the rehabilitation of injured workers from Northern Ontario. First, the sheer distance and remoteness is a problem which is made worse when workers have to travel to Southern Ontario for assessment and treatment.

Second, there is a perception that the specialists in the South are unfamiliar with, and do not understand, the special conditions in the North, and so make unrealistic assumptions and set unattainable goals. This lack of knowledge about the North on the part of the specialists in the present system had led to inappropriate work assessments.

In 1986, 1,074 injured workers from the Northwest Region and 2,569 injured workers from the Northeast Region were off the job for eight weeks or longer. Furthermore, in the Northwest 660 workers were disabled for longer than 90 days, while in the Northeast the number was 1,665 workers. If one calculates that no more than 60% of all these workers ultimately reach the Toronto facility and spend an average of 21 days of assessment and treatment in Downsview Rehabilitation Centre, this represents about 30,000 treatment days. These days are spent away from the family and represents a substantial cost in travel and lodging in addition to the necessary diagnosis and treatment expenses.

The answer to this situation lies in establishing two rehabilitation facilities in the North, one in Thunder Bay to serve the Northwest and one in Sudbury to serve the Northeast. These two cities have the greatest concentration of population, existing health care facilities and professionals in the North; and are the principal geographical locations for transportation and accessibility in their respective regions.

These rehabilitation facilities should be community-based and managed. They would offer medical and functional assessment rehabilitation services that would be purchased by the Workers' Compensation and Rehabilitation Board. Other rehabilitation services, such as vocational, would be purchased as needed within the local community. Therefore, these facilities would also play a major role in co-ordinating an injured worker's rehabilitation program, with the injured

worker's case manager at the Workers' Compensation and Rehabilitation Board.

Services would be purchased as close to the injured worker's home as possible. So, if an injured worker in Sault Ste. Marie needed physiotherapy for an injured arm and it was available in Sault Ste. Marie, then that is where it would be purchased. The injured worker would, therefore, not have to travel to the regional facility in Sudbury.

A model for a regional rehabilitation facility in Sudbury is called the Northeastern Ontario Injured Workers' Rehabilitation Program (IWRP). It is comprised of representatives of business, labour, the municipality, education and health care institutions that want to provide rehabilitation services for injured workers throughout the Northeast.

The IWRP represents a significant community-based initiative to overcome the many shortcomings of the existing WCB rehabilitation system. The Task Force strongly endorses the initiative and recommends the Workers' Compensation and Rehabilitation Board provide initial start-up funding and then purchase services at an appropriate fee. However, the Task Force would also like to see a system where case managers are permitted to make referrals and place injured workers into rehabilitation programs in the centre.

The Non-Urban, Non-Industrial Sector

During the course of its investigations, the Task Force found the WCB had not developed a particularly good relationship with two major communities: the Natives and the agricultural sector.

In general, Natives are unaware of the availability of WCB services to injured workers or have difficulty classifying the type of work performed by band employees. As a result, band members turned to unemployment insurance or welfare for help when an injury occurs. Poor communications and the WCB's lack of understanding of this community paralleled many of the concerns raised by the Ontario Federation of Agriculture.

As a result of the perception that the WCB is designed to serve the industrial and service sectors many farmer owners/operators are unaware of the variety of services available to an injured worker or a family member who is receiving a wage for working on the farm.

An injury to a working member of a family farm can disrupt the whole operation of the farm due to the nature of its workplace. Farmers stated the WCB needed trained staff who had at least a minimum

understanding of the different production techniques and practices used in the agricultural sector.

The Task Force found the conditions that presently exist between the two groups and the WCB, of sufficient concern to warrant special attention. The needs of other sectors such as domestics, hunters, trappers and fishermen are also being neglected.

Final Statement

The experience of the Task Force in the past year was long, painful and emotionally wrenching. The tales of injustice, neglect and rejection recounted by the injured workers throughout the province were so harrowing as to leave the Task Force members disgusted and frustrated.

The WCB has failed to recognize the emergence of a society that is more understanding of the needs of the disabled. It is unresponsive to the fact that hundreds of thousands of workers have become partially or totally disabled in the past years and that society cannot ignore or reject them.

Some of the problems point to legislation that governs service delivery. The *Workers' Compensation Act* was written to eliminate the need for litigation and the search for blame in worksite accidents. It is concerned almost entirely with the concept of an insurance scheme. Little attention is paid to the rehabilitation of the injured worker.

But in the 80s society accepts its responsibility to care for injured workers as human beings, not merely as cogs in industrial wheels. It is not sufficient to restore them physically and then return them to the potentially unsafe working conditions from which they came, or to discard them with woefully inadequate pensions. Clearly the Act must be rewritten to reflect the needs of the workers needs not only for work but for dignity and a quality of life equal to what they had before the injury.

Of course, the main thrust of the Task Force's report has been on the rehabilitation of the injured worker. However, we feel that safety is the cornerstone of rehabilitation and share the concern of the Minister of Labour who has commissioned a number of studies on safety associations. While the amount of money invested in safety associations has risen over the years and employment levels have remained relatively constant, the rate of accidents has increased dramatically.

Some of the blame must also be directed toward the WCB itself. The vagueness of the Act allows for interpretations that can work for the benefit of injured workers or to begrudge them services.

In the Task Force's opinion, the WCB does not spend its funds on vocational rehabilitation effectively which hampers its ability to meet its stated goals. This has a number of important implications. First, referrals to the VRD are kept to a minimum. Second, those who are referred are offered such services as retraining as a last resort and then only if they

are younger and better educated. Third, the Vocational Rehabilitation Division has a high rate of recidivism and closures (where further rehabilitation is deemed unnecessary). Finally, when recidivism and closures are taken into account, about 60% of VRD clients do not become re-employed. (Even this figure is conservative since there is no follow-up to determine how many, in fact, stay employed. As it stands, the board considers them "employed" unless they re-enter the system.)

In effect, the WCB does not serve the rehabilitation needs of all injured workers and those who are referred are served inadequately. To meet its existing goals (not to mention those of the Task Force), the WCB cannot continue to make cost control the primary force behind service delivery. This attitude only leads to an adversarial system fraught with litigation and unemployment for the injured worker.

Therefore, the board must be reconstituted to reflect concern with rehabilitation. The organizational structure must be altered to give prominence to the needs of its clients. Its staff must be hired and shaped into delivering a comprehensive, timely service that reflects a total rehabilitation model rehabilitation in all aspects of impairment. The purpose of rehabilitation must be not only to provide vocational assistance but to restore the injured workers to his or her maximum physical, mental, social, vocational and economic usefulness.

Each injured worker must be able to plan his or her holistic rehabilitation program with a case manager who has training in counselling, empathy towards injured workers and knowledge of the workplace. To ensure injured workers obtain appropriate positions after their rehabilitation, employment specialists such as ergonomists and placement specialists must be hired who have a thorough understanding of the workplace, similar backgrounds to the injured workers and the ability to work closely with employers.

Many employees must also be faulted. It is almost as if once they pay their assessments there is no further responsibility for either prevention or re-employment. Employers ought to do far more than paying their premiums to ensure the wellbeing of their workers. Compensation has become a cheap insurance scheme for some employers rather than a system of justice for injured workers.

Clearly there are unions, employers and groups of injured workers who have taken a leadership role in attempting to change the system. However, there are far too many who do no more than is required by law. Changing a monolithic system such as the WCB requires involvement by caring persons at all levels. But, first of all, it requires the government to enact new legislation and translate it into change throughout the system.

Recommendations to the Minister

Recommendations

Structure of the Organization

1. That the name of the act be changed from *Workers' Compensation Act* to *Workers' Compensation and Rehabilitation Act* to reflect the importance of the rehabilitation function of the board.

2. That the name of the Board be changed to *Workers' Compensation and Rehabilitation Board.*

3. That the Minister of Labour add one injured worker and a vocational rehabilitation practitioner to the corporate board of the Workers' Compensation and Rehabilitation Board.

4. That four divisions be established, each headed by a vice–president.

   a) Policies & Special Services Division
   b) Strategic Planning & Analysis Division
   c) Compensation Services Division.
   d) Rehabilitation Services Division

5. That the management function of the VP Rehabilitation Services shall be the organization and service delivery of all rehabilitation services of the Board. The organizational structure of the Division shall include three executive directors whose functions are outlined in the appended chart. The titles of these directors should be **Director of Service Quality, Director of Service Delivery,** and **Director of**

Rehabilitation Communications

Communications

6. That formal meetings of rehabilitation staff be held at least once a month for the staff to discuss policy and official directives and, in turn, to inform management about their experiences, opinions and attitudes and can discuss difficult or interesting cases.

7. That the Director of Rehabilitation Communications establish and maintain a quarterly newsletter for the rehabilitation staff that would inform as well as solicit information and opinion.

8. That staff of the rehabilitation division be required to take training in counselling people with disabilities and people who are culturally diverse.

9. That the case manager's job requires the manager to take time to go to conferences, workshops, field trips and visits to job sites, so that two-way communication avenues be kept open.

10. That WCRB establish a program evaluation system to track the effectiveness of its rehabilitation services and to conduct follow-up studies.

11. That the rehabilitation division establish its own communications arm which will serve to inform, transmit opinion, receive plaudits and complaints, and recommend improvements in service delivery.

12. The WCRB establish a research fund to finance internal and external research into applied and basic problems that deal with conditions of disablement, occupational health and safety, outcome research and other areas of interest to rehabilitation of injured workers.

The Right to Total Rehabilitation

13. Any worker who sustains a serious injury or a debilitating disease linked to the workplace, shall have the statutory right to all rehabilitation required by that worker. Rehabilitation shall be defined as "to assist workers who have suffered occupational injuries or debilitating diseases linked to the workplace in the process of restoration, to the fullest physical, mental, social, vocational and economic independence to the maximum possible extent". Serious shall be defined as a situation in which the worker is unable to return to the job within 30 days of injury.

14. That the board take a proactive role in identifying those injured workers who have not received, have been denied, or were never referred to rehabilitation services and that the board accept the responsibility of supplying satisfactory rehabilitation services and ensuring financial security.

15. That all cases in WCB which have been open more than 30 days but not referred to Vocational Rehabilitation Services be referred for service under the broader definition of rehabilitation.

16. That the board take a proactive role in identifying those injured workers who have received vocational rehabilitation services but are dissatisfied with the rehabilitation services received and that the board accept the responsibility of supplying satisfactory rehabilitation services and ensuring financial security.

Re-Employment Issues

17. That the Ministry of Labour draft a resolution similar to the Quebec legislation which reads: "No person may refuse to hire a worker because the worker has suffered an employment injury if the worker is able to carry on the employment contemplated.

18. That a worker who is injured at the workplace or contracts an occupational disease shall have the statutory right to return to the preinjury job. Where the worker is no longer capable of performing that job he or she shall have the right to another job in the same enterprise, respecting seniority rights.

19. That where the company no longer exists, the Injured Worker shall be assisted by the Rehabilitation Division of WCRB to find alternate employment.

Assessment and Work Adjustment Training

20. That where a dispute arises among medical practitioners regarding the diagnosis and functional assessment of the injured worker, the case manager shall request the Ontario College of Physicians and Surgeons to appoint a specialist to adjudicate the dispute.

21. That adjudication shall take place within 30 days of notification of the existence of the dispute and that the results shall be given to the case manager.

22. During the period of review by the adjudicator full financial benefits shall be continued.

23. That should no agreement in diagnoses then be obtained, or the worker or employer refuse to concur with the outcome, the case shall be taken to an appeals system for adjudication.

24. That the WCRB take a pro-active role in working with the community to reduce environmental barriers to the employment of people with physical or emotional injuries.

25. That the trend of decreasing expenditures for training be reversed to reflect the value of training as a rehabilitation tool for injured workers.

26. That the Minister of Labour initiate and co-ordinate efforts among the provincial and federal government, management and labour to establish sector-based skill training centres in appropriate areas of the province open to all people requiring skill training.

27. That the management of the sector-based rehabilitation centres be constituted with labour and management, or, where labour is not organized, with rehabilitation practitioners and worker representatives from the community.

28. That the Minister of Labour, in co-ordination with the Minister of Community and Social Services, and in co-operation with representatives from industry and community based rehabilitation agencies, initiates the development of accreditation standards for rehabilitation workshops and activity facilities in Ontario.

29. That accreditation standards should be put into place within two years of receipt of this recommendation.

30. That WCRB refer clients for assessment and work adjustment only to those workshops that are accredited and can demonstrate an evaluation process to monitor their quality of service.

31. That the Minister of Labour initiate and co-ordinate efforts among the provincial and federal government to establish affirmative industries in all the major communities in Ontario to supply employment that would allow the gradual return of injured workers to competitive employment.

32. That the WCRB render such rehabilitation and compensation services as necessary to restore disabled workers to social and economic independence.

33. That where the case manager is dissatisfied with a report from purchased rehabilitation services, the case manager must be able to purchase alternative services.

34. That where a worker contests a recommendation made by the case manager, the worker shall have the right of appeal to the case manager's supervisor. The worker always shall have the right to request another case manager following a review by the supervisor.

35. That where the employer or the employee is dissatisfied with the outcome of the recommendations reached by the case manager and the case manager's supervisor, they shall retain the right to appeal to the appeals system.

Job Modification

36. That the WCRB take a pro-active role in promoting job modification practice in Ontario by increasing the number of trained ergonomists on staff making use of trained personnel in the community.

37. That the WCRB advertise its availability to assist businesses with expert advice and financial incentives in the development of job modification programs.

38. That personnel hired by the WCRB in the capacity of ergonomists shall have appropriate training in ergonomic planning and assessment.

39. That the WCRB shall respond in 30 days to employer requests for assistance in job modification.

Case Management

40. That each file of an injured worker that comes to Rehabilitation Services shall become the responsibility of a single staff worker, called the case manager, who shall receive the file from the intake counsellor and be responsible for choice and delivery of appropriate service until one year after the file is closed.

41. That the case manager shall be responsible for appropriateness, comprehensiveness and continuity of the service provision.

42. That the functions of the case manager shall include the following:

    - to assess the injured worker's needs
    - to develop a therapeutic relationship with the injured worker
    - to plan and organize all rehabilitation services
    - to procure and expedite services

- to keep records of services given and costs incurred
- to advocate for and represent the client
- to organize and manage the entire caseload.

43. That the process of rehabilitation service delivery followed by the case manager shall be as illustrated in the flow chart.

44. That the case manager involve the injured worker as a partner in all rehabilitation decisions so that the injured worker shall be a participant in all phases of service selection.

45. The training of the case manager shall be that of the rehabilitation counsellor at a level that would give her or him recognition as a senior member of the rehabilitation team.

Rehabilitation Services Providers

46. That rehabilitation counsellors with experience be recognized as case managers in the rehabilitation services delivery system.

47. That case managers shall have the freedom to design individualized rehabilitation programs to fit the uniqueness of every injured worker.

48. That each case manager shall provide direct services to injured workers to the extent that his or her training, skills, and abilities will allow.

49. That rehabilitation counsellors be encouraged to investigate and select services in the community not provided by WCRB, based on assessment of effectiveness and quality of service.

50. That all rehabilitation counsellors be required to continually visit and monitor employment conditions in the workplace.

51. That all rehabilitation counsellors be required to present the WCRB to employers, workers, professional groups and the public at large by maintaining positive two-way communications.

52. That rehabilitation counsellors presently employed at Workers' Compensation Board be required and encouraged to upgrade their formal education to a graduate level in a program that stresses counselling skills.

53. That all personnel to be hired in the future at WCRB as rehabilitation counsellors shall have training at a graduate level in programs that stress counselling skills. That recognition be

given to work experience and that the board provide the time and financial incentives to train to a graduate level.

54. That the Minister of Labour work with the Minister of Colleges and Universities to actively promote the establishment in Ontario of a graduate level program that would train rehabilitation counsellors for certification.

55. That the Minister of Labour join with the Minister of Health and Minister of Community and Social Services to actively promote the establishment in Ontario of a system of certification of rehabilitation counsellors.

56. That the WCRB actively encourage and fund a programme of continuing education and upgrading of its staff so that they continue to maintain their skills.

57. That the WCRB be required to provide on-site training at industries in the community so that rehabilitation counsellors maintain and enhance knowledge of the workplace.

58. The caseload size of rehabilitation counsellors should be allowed to vary according to the amount of work each case requires, but should be set by management in consultation with the counsellors with due regard to the demands of a high quality of service and not allowed to rise above 50.

59. That employment specialists be hired from among the working population in each community where a regional rehabilitation office exists to work with the case managers in formulating rehabilitation goals and programs.

60. That employment specialists shall assist in setting up retraining sites in the community and also assist injured workers in job search.

61. That employment specialists be representative of the ethnic populations of their communities and proportionally representative of the sectors of the injured workers population.

62. That these employment specialists be provided by the board with training from a qualified institution in Ontario that offer educational opportunities in rehabilitation, job management and ergonomics.

Early Intervention

63. That when workers are injured at the workplace, or are discovered to have contracted a debilitating disease linked to the workplace, the following procedure in partnership with the injured worker, be followed:

    a) the injured worker be provided immediate Acute Health Care Services.
    b) A claims file shall be opened at the nearest WCRB office.
    c) If the injury or disease is considered by Acute Health Care Services to be serious, or is a reoccurrence of the previous injury, or is reopened, Health Care Services shall notify the claims officer immediately who shall then transfer the file to an intake counsellor of the WCRB Rehabilitation Services for immediate initiation of rehabilitation services.
    d) If the injured worker is unable to return to work within 30 days, or if a file remains open for 30 days for whatever reason, the claims officer shall transfer the file to the intake counsellors of the WCRB for immediate initiation of services.
    e) All injured workers who are receiving rehabilitation services shall receive full benefits as long as they are receiving these services.
    f) Injured workers who have not been referred to rehabilitation services can request rehabilitation services and shall be referred immediately to the intake counsellor for service.

64. That the WCRB takes a pro-active role in contacting injured workers as soon as possible after the event, informing them of their rights and insuring that the injured workers fully understand their rights and obligations.

Regionalization

65. That the Minister of Labour adopt all the recommendations of the Downsview Rehabilitation Centre Review Team, including those concerned with the cessation of vocational assessments at Downsview Rehabilitation Centre.

66. That medical and functional assessment and therapeutic services be purchased from local community hospitals wherever possible. Where such services do not exist, the Minister of Labour should work closely with the Minister of Health to assist actively in the establishment of medical and functional assessment centres in the local communities.

67. That rehabilitation services, in all its facets, including medical, psychosocial, vocational and work adjustment, should be purchased by the Case manager from community institutions, organizations or private services in the communities wherever they are available.

68. That when an appropriate rehabilitation service does not exist in the local community, WCRB should assist actively with advice and financial incentives in the establishment of such services.

69. That WCRB should decentralize its services and establish rehabilitation offices staffed by case managers and employment specialists in local communities as far as possible.

Northern Ontario: Decentralization of Rehabilitation Services

70. That community based regional rehabilitation facilities be established in Thunder Bay and Sudbury to provide rehabilitation services to injured workers in Northern Ontario, with:

    a) initial funding provided by the WCRB, and
    b) that the WCRB purchase services on an appropriate fee-for-services basis.

71. That the WCRB case manager in conjunction with the rehabilitation facilities purchase rehabilitation services from the community.

72. That rehabilitation services be purchased as close as possible to the injured worker's residence.

73. That the Northeastern Ontario Injured Workers' Rehabilitation Program open referrals from managers of the WCRB.

74. That the community in Thunder Bay and the Northwest region of Northern Ontario, with an interest in the rehabilitation of injured workers, develop a rehabilitation facility using the community based model of the Injured Workers Rehabilitation Program for Northeastern Ontario as a guide.

75. That the Minister of Labour in conjunction with the Minister of Northern Development and Mines, the Minister of Health and the Minister of Colleges and Universities, develop programs and incentives that will encourage and assist students in Northern Ontario to enter into education and training in the health care

field in greater numbers and to desire employment in their field of study and profession in Northern Ontario.

76. That the Minister of Labour in conjunction with the Ministers of Intergovernmental Affairs, Northern Development and Mines, and Health, undertake discussions with their federal government counterparts to encourage the possible immigration of health care professionals who wish to practice in Northern Ontario.

Non-urban, Non-industrial Sector

77. That the WCRB initiate a dialogue with representatives of Native Bands to discuss the present rating schedule and rehabilitation needs of the community, taking into account such factors as the unique socioeconomic existence of Natives in Ontario.

78. That the WCRB initiate a dialogue with representatives of the agricultural community towards providing rehabilitation services that are relevant, accessible and appropriate for that community.

79. That the Director of Communications of the WCRB Rehabilitation Division develop channels of communication between the WCRB and the native community and the agricultural sector, with the goal of establishing the following:

- a discussion of benefits and costs, and the potential usefulness of rehabilitation;
- clear and complete guidelines for undertaking coverage by WCRB and making full use of its services and benefits;
- an outline of these services and benefits as they apply to Native people in urban, rural, and remote settings, and to traditional and non-traditional forms of work;

80. That the WCRB identify other non-industrial and non-urban sectors or communities, such as the fishing industry and non-Native hunters and trappers in Ontario, and ensure that effective lines of communication exist or are established so that rehabilitation services to these sectors are relevant and effective.

Review

81. That a re-evaluation be made on the targeting of safety dollars.

82. That rehabilitation be enshrined in the Act as Regulation 949 under the *Workers' Compensation Act*.

83. That a tri-party committee (labour, industry and ministry) be established to convert the Vocational Task Force recommendations into regulations.

84. That a tri-party committee (labour, industry and ministry) be established, either as a standing committee or otherwise, with the power to make amendments, adjustments and recommendations to the regulations.